

HEALTH CARE ADVISORY BOARD

Meeting Summary

April 8, 2013

MEMBERS PRESENT

Marlene Blum, Chairman
Rose Chu, Vice Chairman
Bill Finerfrock, Vice Chairman
Dr. Tim Yarboro
Ann Zuvekas
Ellyn Crawford
Judith Beattie
Francine Jupiter

STAFF

Sherryn Craig

GUESTS

Ron Bialek, President and CEO, Public Health Foundation (PHF)
Pete J. Rigby, Jr., PE, Partner, Vice President, Paciulli, Simmons & Associates, Ltd.
Javier Arencibia, Arencibia Architects Inc.
Dong Chul Choi, President, Agape Health Management, Inc.
Tiffany Paredes-Turner, Paciulli, Simmons & Associates, Ltd.
Joseph Gorney, Office of Comprehensive Planning, Zoning Evaluation Branch
Michael Forehand, Inova Health System
Gloria Addo-Ayensu, MD, MPH, Health Department
Rosalyn Foroobar, Health Department
Victoria Cardoza, Analyst, Partnership for a Healthier Fairfax

Call to Order

The meeting was called to order by Marlene Blum at 7:39 p.m.

March Meeting Summary

The minutes from the March 11, 2013 meeting were accepted as submitted.

Presentation on Public Health

Ron Bialek, President and CEO of the Public Health Foundation (PHF), presented on roles, issues, and trends in public health based on his experience of working with health departments throughout the United States.

Given our population's increasing health needs and the rising costs of health care, there is greater interest in public health working more closely together with health care (i.e., the clinical delivery of health services).

The National Prevention Strategy is a result of the Affordable Health Care Act. Various federal agencies are represented, and behavioral issues and enabling factors are incorporated into the model.

The National Prevention Council has identified three main areas for all federal agencies:

- Consider prevention and health within departments and encourage partners to do so voluntarily;
- Increase tobacco free environments within its departments and encourage partners to do so voluntarily as appropriate; and
- Increase access to healthy, affordable food within its departments and encourage partners to do so voluntarily as appropriate.

The commitment of all federal agencies to improving public health represents a major c-change.

The Institute of Medicine has identified foundational capabilities that all governmental public health agencies should demonstrate in order to protect citizens and promote public health. These capabilities include:

- Informational systems and resources;
- Health planning that's accountable to all citizens;
- Partnership development and community mobilization that invites people to the table to take action to improve the health of the community;
- Policy development analysis and decision support which may require agencies to present a policy/option different ways for different audiences;
- Quality assurance;
- Communication and coordination to inform the public what government agencies are doing to protect and promote health and coordinate those messages; and
- Public health research, evaluation and quality improvement, which incorporates root cause analysis to determine the true cause of public health problems.

There is ongoing discussion to form a federal-state relationship/entity similar to Medicaid to ensure that foundational capabilities are implemented properly and exist at different levels.

Discrete programs are funded by discrete government dollars and tend to operate within the same organization but are not necessarily coordinated or well defined because of the way they're funded.

There are over 350 local health departments in Massachusetts. In order to change governmental public health, three things need to happen:

- Modernize core systems using surveillance and epidemiology as a case study;
- Streamline categorical programs by breaking down silos and emphasizing approaches to have a cross cutting impact within health. Greater use of block grants would allow localities to put programs together where they make sense.

- Focus investment in partnerships (e.g., Community Transformation Grants model for leadership and sharing resources) because public health cannot protect, promote, and improve health alone.

The CDC is beginning to consider more applications for waivers, but it requires public health to become more innovative. Agencies need to think about people and communities, not individual programs.

The Community Health Planning and Improvement process is cyclical with feedback loops in between partnerships and planning and assessments. In the past, CDC has primarily been focused on assessments. One key to having a successful partnership is to identify opportunities for small wins and early action. Steps in the Community Health Planning and Improvement cycle include Plan, Do, Check, and Act.

It is more difficult to measure strategies and interventions, which is why small wins are important because they do not require a lot of resources and allow public entities to get out of the assessment box mentality. Agencies are encouraged to develop small pilots in order to test policies/projects. Corrections or adjustments can be made in the Check phase and then scaled up for larger audience/targets in the Act step.

One of the downsides to external funding is that it can drive an agency's priorities, dictate timeframes, and create an unrealistic policy environment (e.g., promoting anti-tobacco policies in tobacco manufacturing/farming states).

Challenges to Community Health Planning and Improvement include:

- Continued large numbers of uninsured;
- Provider shortages;
- Lack of evidence to support population-based interventions;
- Lack of trust;
- Demand for short-term impact for long-term problems; and
- Need to coordinate community policies and services across disciplines and sectors.

Despite the sequestration, there are many opportunities for Community Health Planning and Improvement and leveraging resources from partnerships:

- Community Transformation Grants are likely to continue and expand;
- Accountable Care Organizations like that in Akron, Ohio where several sectors joined together to develop programs to reduce diabetes. Within 18 months of implementation, the average cost per month of care for individuals with diabetes decreased by 10% per month and by 25% after one year. Oregon also created a coordinated care organization using a Medicaid waiver.
- Electronic Health Records/Health IT

- IRS Community Benefit Requirements;
- Increasing evidence;
- Consumer and Policy Maker Demands;
- Creative and innovative solutions to difficult, ongoing, and complex community health problems by turning funders' priorities into community solutions and not letting success get in the way. For example, despite tobacco being CDC's number one priority, communities should consider reframing the issue to meet local objectives (e.g., training/recruiting more providers to counsel patients on tobacco cessation). The CDC wants success stories which demonstrate to Congress and the Administration that solutions are being achieved locally.

Mr. Bialek agreed that using a regional approach to address health issues is ideal, but often difficult. Successful regional collaborations include Vermont (e.g., global health budget) and Western North Carolina (partnership of hospitals and health departments).

Other opportunities for public health include:

- National Voluntary Accreditation/Accountability: Eleven health departments have completed the accreditation process.
- National Public Health Performance Standards
- Core Competencies for Public Health Professionals
- Healthy People 2020 National Prevention Strategy
- Health in All Policies
- Affordable Care Act
- Performance Improvement Managers
- Tools and Methods for Quality and Performance Improvement

In conclusion, Mr. Bialek underscored the importance of focusing on the root causes of poor health. He shared the example of Orange County, Florida and its increasing syphilis rate. This health outcome was not a function of unprotected sex and risky behavior patterns, but a result of gossip and poor morale among staff that managed and administered the program. Once Orange County engaged its Human Resources Department, staff retention increased and syphilis rates decreased by 30% in nine months. Public health must reconsider the way it addresses outcomes by focusing on what's behind the problems, not just treating the symptoms.

Agape Adult Day Health Care Center

At its February 11, 2013, meeting, the Health Care Advisory Board deferred its recommendation until the April 8 meeting on Agape Adult Day Health Care Center's application to relocate its existing operation from Springfield to the Mason District. The HCAB provided the applicant with written follow up questions, the answers to which were provided in the April meeting packet.

Under Financial Information, Dong Chul Choi, President, Agape Health Management, Inc., clarified that the company donates \$8,000-\$10,000 to the Missionary Charity.

AADHCC receives \$120,000 from the Child and Adult Care Food Program (CACFP), the federal program administered by the United States Department of Agriculture's (USDA) Food and Nutrition Service (FNS) that provides snacks and meals to children and adults as part of the day care they receive.

In addition to the CACFP income, AADHCC reported annual income in the amount of \$1.2 million from Virginia Medicaid. The annual operating costs for the Springfield AADHCC are \$950,000, resulting in a net profit of \$370,000 before taxes. The HCAB felt that as a percentage of revenue, the profit margin was substantially higher than other service providers.

The operating costs for the new facility will be higher. Development and construction costs are projected at \$1.5 - \$2 million.

At the existing facility, 93 (88.57%) of the facility's participant population are authorized to administer their own medications. It was noted during discussion that to be Medicaid eligible for adult day care services, participants typically do not have the ability to self-medicate; they have health conditions that cause impairment or disability. The criteria for Medicaid eligibility was characterized as very stringent.

Mr. Choi stated that many of AADHCC's seniors are qualified for Medicaid, but that they can take medications by themselves. With respect to the participant population at the new facility, the applicant expected that almost all will qualify for Medicaid. With respect to how participant eligibility is certified, Mr. Choi indicated that AADHCC's participants live not just in Fairfax, but are from several local jurisdictions (e.g., Arlington County, City of Alexandria, Prince William County, etc.). He said a public health nurse and social worker from the appropriate jurisdiction evaluate the participant, and together with the family physicians and family/caregivers, certify the client as Medicaid-eligible and develop a care plan, including medication administration.

In response to whether AADHCC is using the Medicaid-approved provider, Logisticare, to transport Medicaid patients, Mr. Choi said AADHCC absorbs the costs for transportation.

Rose Chu moved that the HCAB recommend the Board of Supervisors approve the applicant's proposal to relocate and expand its existing adult day health care operation. Ann Zuvekas seconded. The motion carried unanimously.

AADHCC is scheduled to appear before the Planning Commission on May 9 and the Board of Supervisors on June 4.

Community Transformation Grant (CTG)

Victoria Cardoza, Project Analyst for the Community Transformation Grant, provided an overview and update on the Partnership for a Healthier Fairfax in addition to soliciting community input from the HCAB.

Three years ago, the County initiated an Assessment Phase, using the Mobilizing for Action through Planning and Partnerships (MAPP) process, culminating in the formation of the Partnership for a Healthier Fairfax (PHF). The PHF is a community coalition of public, nonprofit, faith and business organizations that have joined forces to improve public health by increasing awareness of causes of poor health, advocating change and mobilizing resources.

In the Prioritization Phase, 91 individuals from the PHF Coalition participated in five PHF Strategic Issues Team (SITs) and a Policy, Systems and Environmental (PSE) Scan for the purpose of identifying community improvement priorities.

The SITs identified 199 opportunities for change. The application of criteria reduced the number of priority opportunities to 66, which when categorized into common themes, left 18 remaining. The 18 opportunities were narrowed into six areas of focus

The Prioritization Phase of the County's Community Health Improvement Process also involved the formation of workgroups around the CTG's strategic issues. Sixty-eight PHF members participated, and the workgroups sought community input to inform community improvement priorities and strategies. The Live Healthy Initiative aligns well with the MAPP strategic issue areas and the grant's strategic directions.

The Community Transformation Leadership Team, comprised of 24 high level executive leaders, selected and prioritized the six strategic directions and their corresponding objectives and activities. The Leadership Team, along with input from other community groups and organizations, will inform the framework of the Partnership's grant proposal to transition from capacity building to implementation.

The CDC has requested that applicants provide two proposals: a scaled down version totaling \$499,000 per year for four years and a larger scale version totaling \$999,000 per year over four years.

As the CTG moves toward implementation, Ms. Cardoza assured the HCAB that the transition does not signal the end of the community health improvement plan, which will consider both the strategic directions submitted to the CDC and the Partnership's SIT priorities. The SITs will reconvene during the implementation phase.

Other Business

The HCAB will convene at 6:00 pm on May 13 to brainstorm the criteria it uses to make decisions and recommendations on health issues.

A discussion regarding the use of observation versus inpatient admissions will be scheduled for the June HCAB meeting.

The HCAB may schedule a presentation from Leslie Johnson, Zoning Administrator, during its September meeting. However, some behind-the-scenes work needs to occur in advance of any presentation.

Marlene Blum learned from the Department of Family Services (DFS) that Sunrise Assisted Living facilities have stated that the agreement to provide beds for low income patients has expired. Given that Sunrise is under new ownership, there was interest in inviting representatives to a future HCAB meeting. Sherryn Craig will work to contact Sunrise using the point of contact provided by DFS. Staff will also research the parameters of Sunrise's commitment to the HCAB and whether there is a way to extend agreements to future owners/purchasers.

Rosalyn Foroobar will research the Health Department's role in promoting Virginia's Safe Haven law.

There being no further business, the meeting adjourned at 9:44 pm.